



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

May 9, 2014

## Public Health & Emergency Preparedness Bulletin: # 2014:18 Reporting for the week ending 05/03/14 (MMWR Week #18)

### CURRENT HOMELAND SECURITY THREAT LEVELS

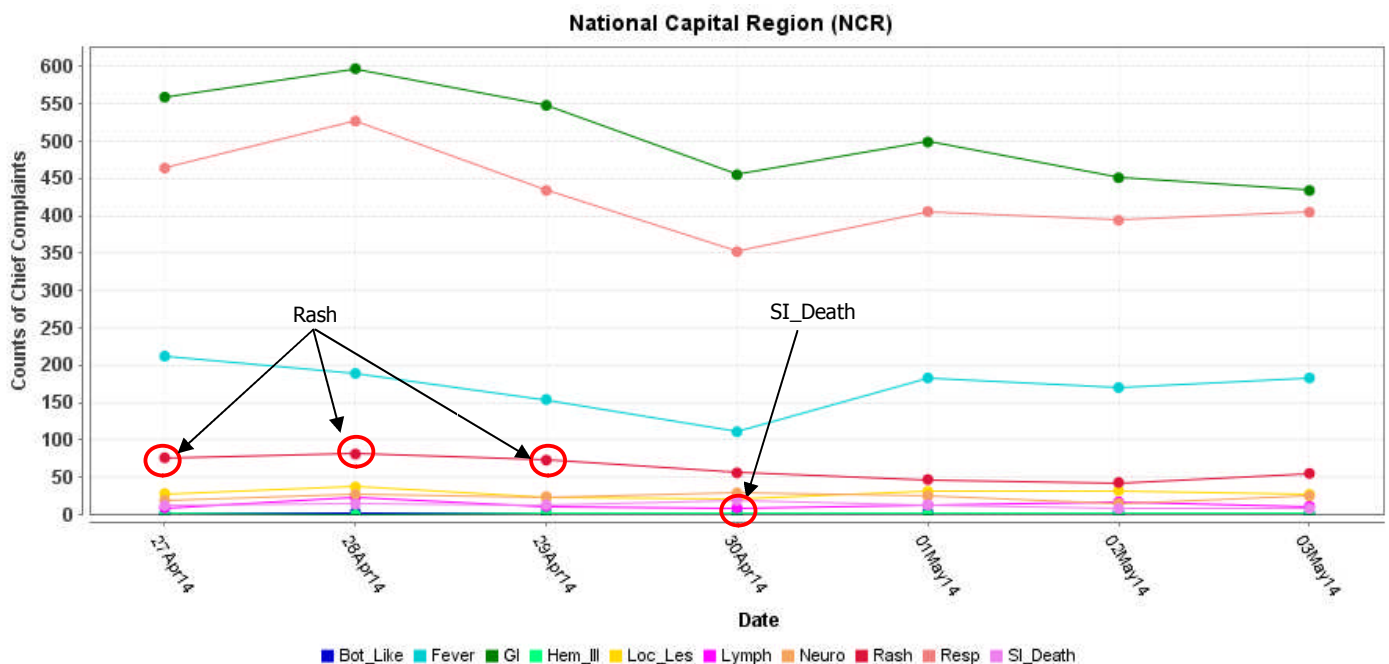
National: No Active Alerts  
Maryland: Level Four (MEMA status)

### SYNDROMIC SURVEILLANCE REPORTS

#### **ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):**

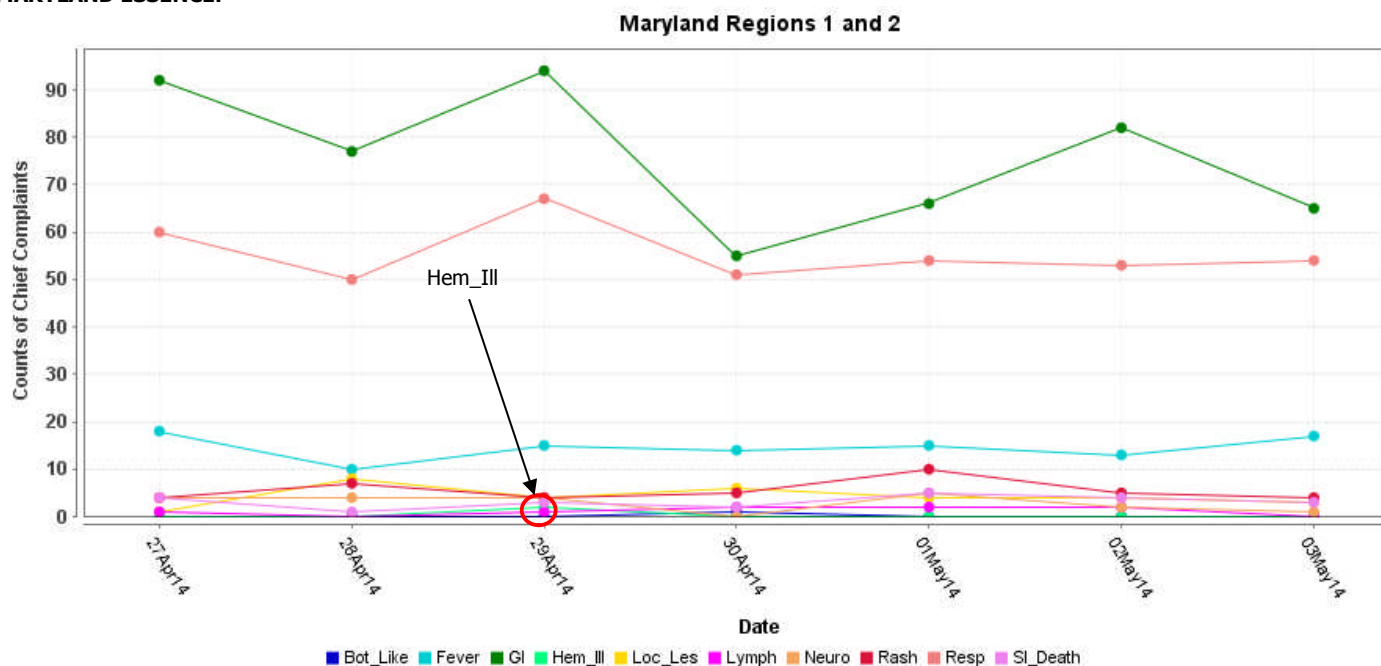
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

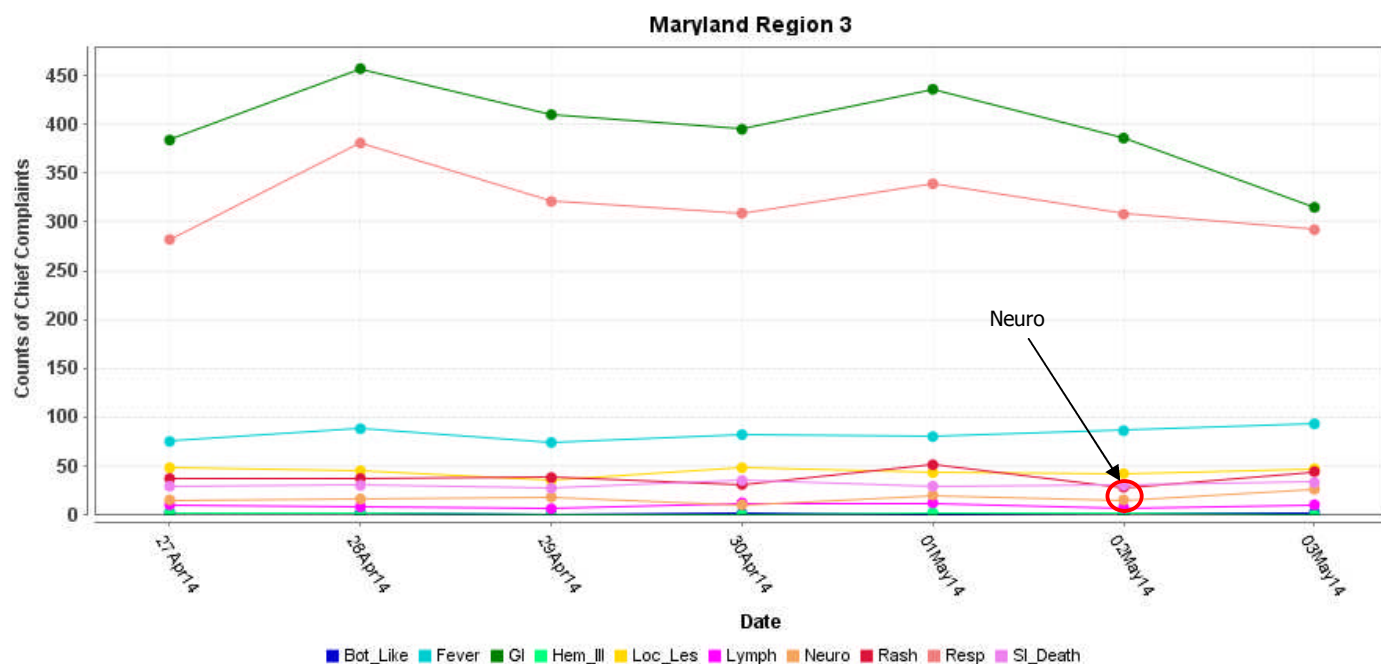


\*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

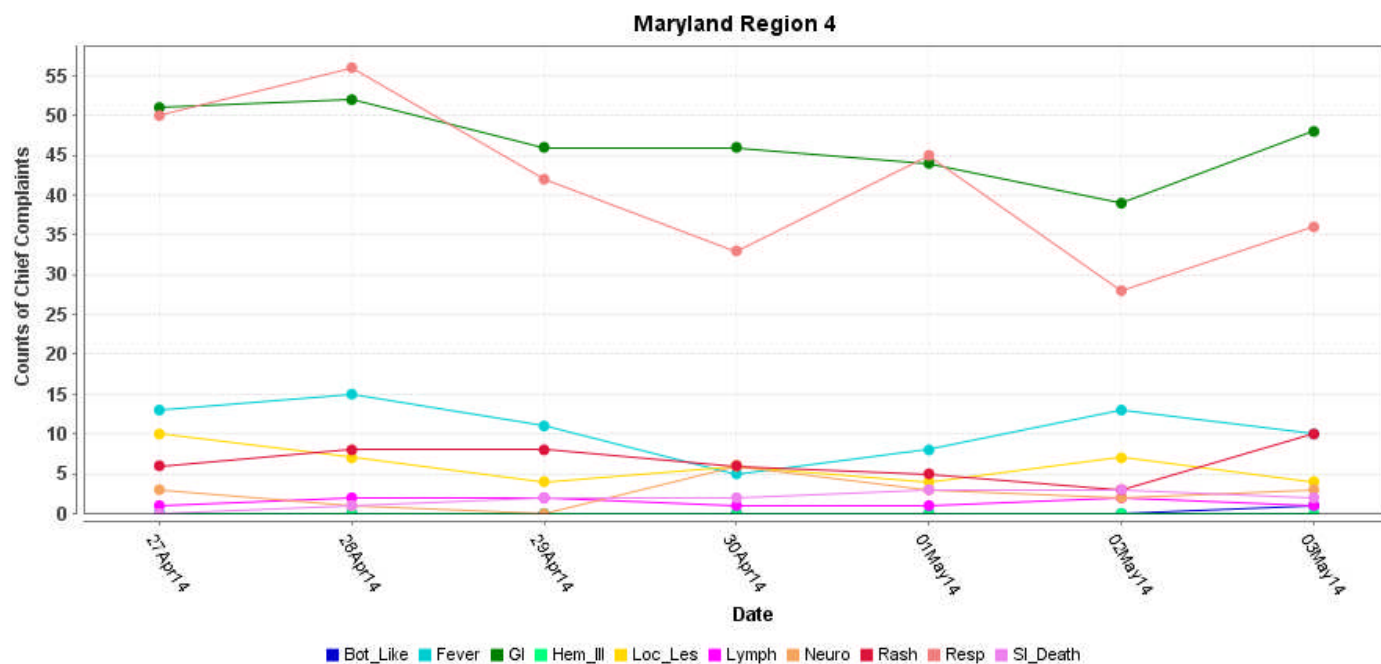
**MARYLAND ESSENCE:**



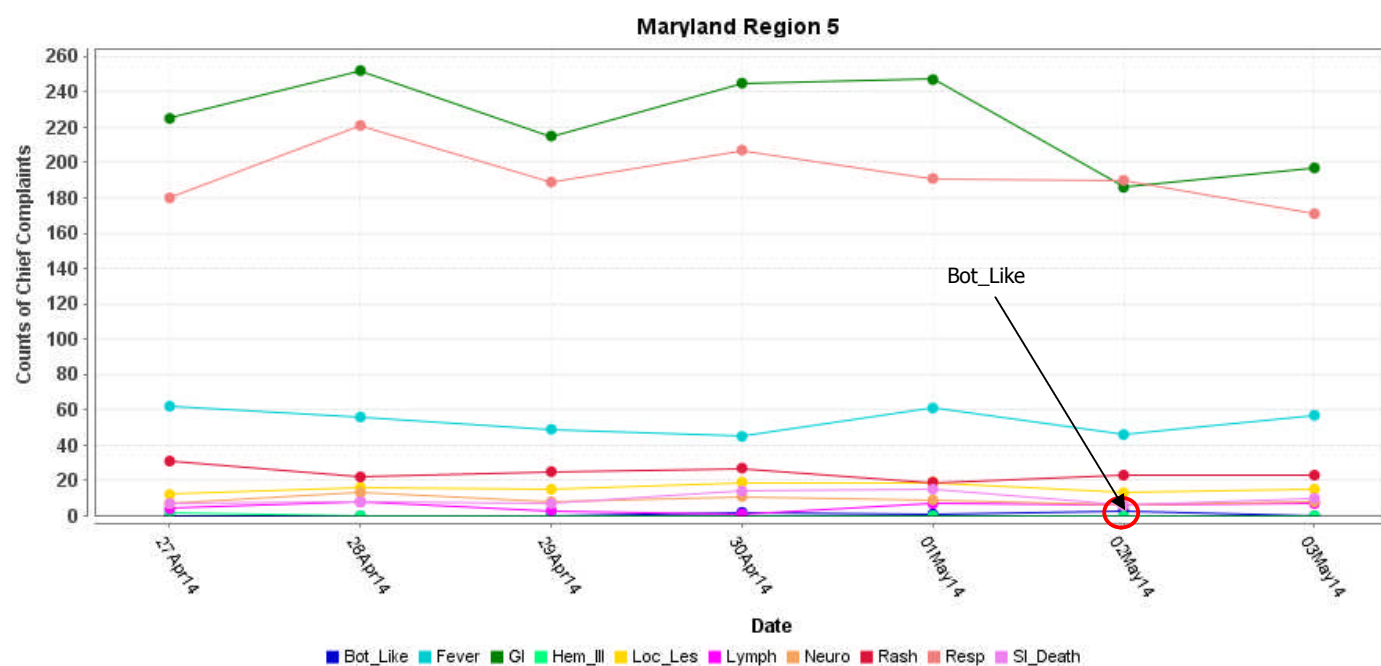
\* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



\* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



\* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE

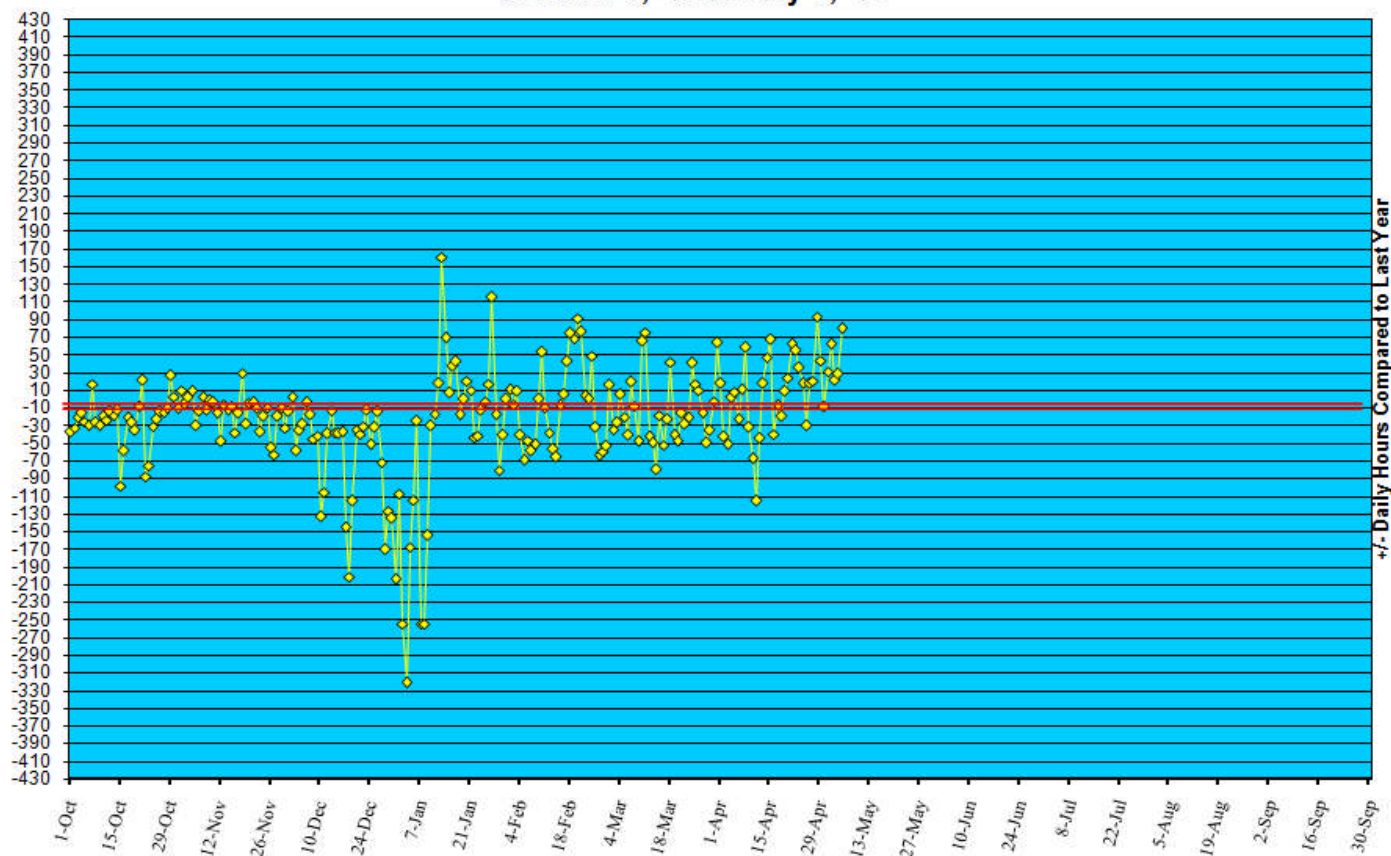


\* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

## REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

**YELLOW ALERT TIMES (ED DIVERSION):** The reporting period begins 10/01/13.

### Statewide Yellow Alert Comparison Daily Historical Deviations October 1, '13 to May 3, '14



## REVIEW OF MORTALITY REPORTS

**Office of the Chief Medical Examiner:** OCME reports no suspicious deaths related to an emerging public health threat for the week.

## MARYLAND TOXIDROMIC SURVEILLANCE

**Poison Control Surveillance Monthly Update:** Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in March 2014 did not identify any cases of possible public health threats.

## REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

### COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

#### **Meningitis:**

New cases (April 27 - May 3, 2014):

Prior week (April 20 - April 26, 2014):

Week#18, 2013 (April 28 - May 4, 2014):

#### **Aseptic**

7

8

5

#### **Meningococcal**

0

0

0

## 7 outbreaks were reported to DHMH during MMWR Week 18 (April 27-May 3, 2014)

### 6 Gastroenteritis Outbreaks

- 2 outbreaks of GASTROENTERITIS in Nursing Homes
- 2 outbreaks of GASTROENTERITIS in Assisted Living Facilities
- 1 outbreak of GASTROENTERITIS associated with a School
- 1 outbreak of GASTROENTERITIS associated with a Restaurant and Rental Hall

### 1 Foodborne Outbreak

- 1 outbreak of GASTROENTERITIS/FOODBORNE associated with a Restaurant

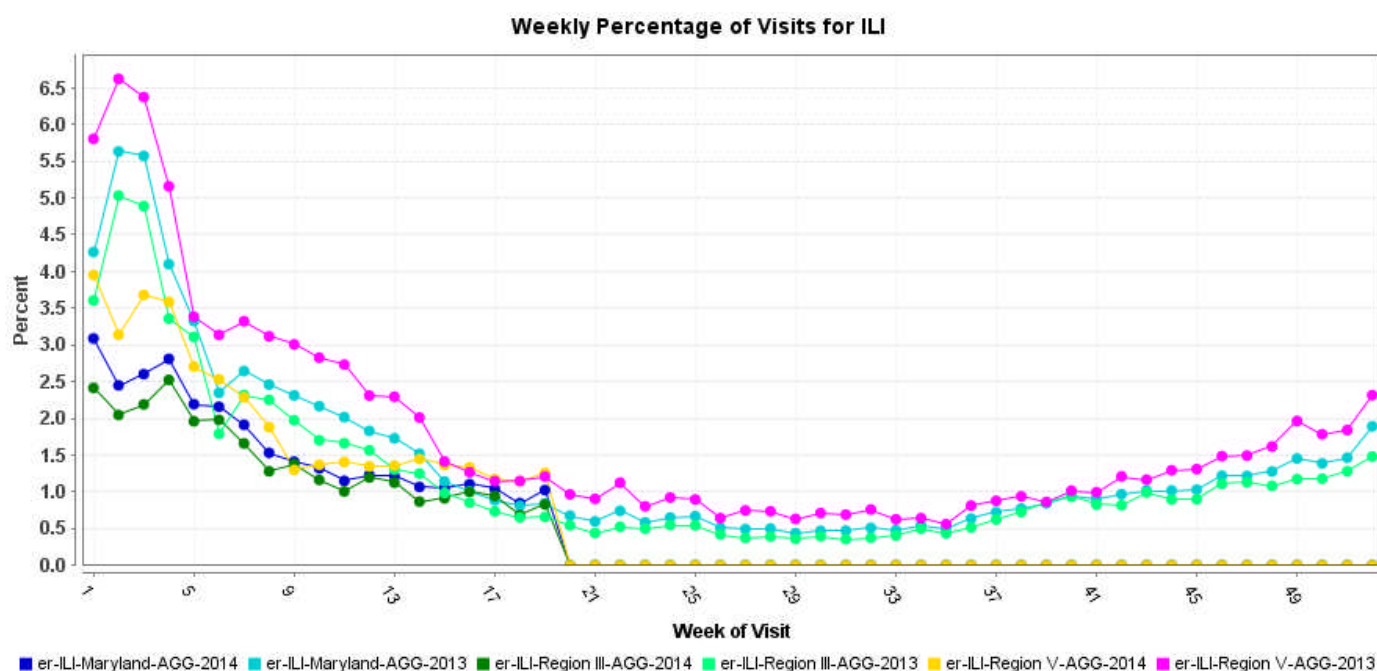
## MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 18 was: Local with Minimal Intensity.

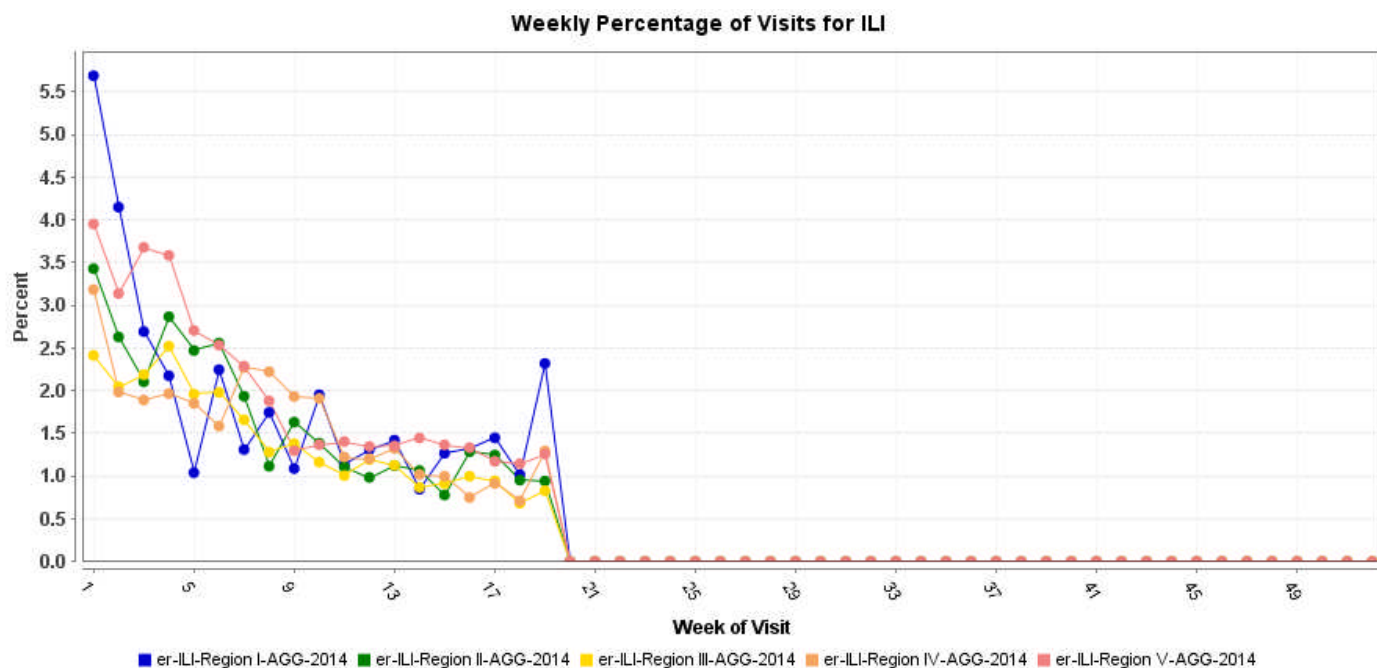
## SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



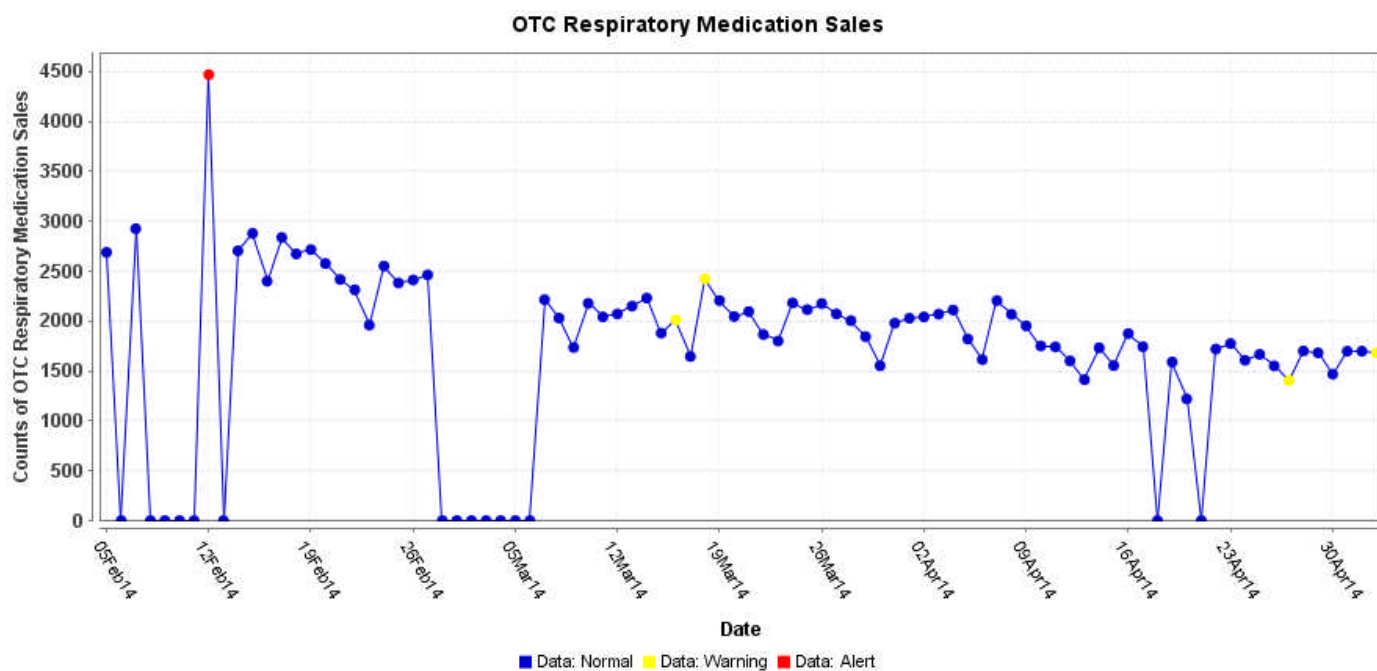
\* Includes 2013 and 2014 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



\*Includes 2014 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

### OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



## **PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS**

**WHO update:** The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

**Alert phase:** This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of January 24, 2014, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 650, of which 386 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

**AVIAN INFLUENZA (H7N9):** On [23, 20 and 17 Apr 2014], the National Health and Family Planning Commission (NHFPC) of China notified WHO of 6 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus.

Details of the cases reported on [23 Apr 2014] are as follows:

- A 35-year-old health-care worker from Wuxi City, Jiangsu Province. She became ill on [10 Apr 2014], was admitted to a hospital on [14 Apr 2014] and is currently in a critical condition.
- A 50-year-old man from Yongzhou City, Hunan province. He became ill on [10 Apr 2014], was admitted to a hospital on [19 Apr 2014] and is currently in a critical condition.

Details of the cases as reported on [21 Apr 2014] are as follows:

- A 34-year-old man from Wuxi City, Jiangsu Province. He became ill on [10 Apr 2014], was admitted to a hospital on [16 Apr 2014], and is currently in a critical condition.
- A 55-year-old woman from Shantou City, Guangdong Province. She became ill on [6 Apr 2014], was admitted to a local hospital on [17 Apr 2014], and is currently in a critical condition.

Details of the cases notified on [17 Apr 2014] are as follows:

- A 60-year-old man from Changzhou City, Jiangsu Province. He became ill on [8 Apr 2014], was admitted to a hospital on [13 Apr 2014], and is currently in a severe condition. He had a history of contact with poultry before he became ill.
- A 70-year-old man from Tongling City, Anhui Province. He became ill on [21 Mar 2014], was admitted to a hospital on [25 Mar 2014], and died on [14 Apr 2014].

The Chinese Government has taken the following surveillance and control measures:

- strengthen surveillance and situation analysis;
- reinforce case management and treatment; and
- conduct risk communication with the public and release information.

The overall risk assessment has not changed (see WHO Risk Assessment under "Related links").

The previous report of avian influenza A(H7N9) virus detection in live poultry exported from mainland China to Hong Kong SAR shows the potential for the virus to spread through movement of live poultry; at this time, there is no indication that international spread of avian influenza A(H7N9) has occurred. However, as the virus infection does not cause signs of disease in poultry, continued surveillance is needed.

Further sporadic human cases of avian influenza A(H7N9) infection are expected in affected and possibly neighbouring areas.

Should human cases from affected areas travel internationally, their infection may be detected in another country during or after arrival. If this were to occur, community level spread is unlikely as the virus does not have the ability to transmit easily among humans. Until the virus adapts itself for efficient human-to-human transmission, the risk of ongoing international spread of H7N9 virus by travellers is low.

WHO advises that travellers to countries with known outbreaks of avian influenza should avoid poultry farms, or contact with animals in live bird markets, or entering areas where poultry may be slaughtered, or contact with any surfaces that appear to be contaminated with faeces from poultry or other animals. Travellers should also wash their hands often with soap and water. Travellers should follow good food safety and good food hygiene practices.

WHO does not advise special screening at points of entry with regard to this event, nor does it currently recommend any travel or trade restrictions.

As always, a diagnosis of infection with an avian influenza virus should be considered in individuals who develop severe acute respiratory symptoms while travelling or soon after returning from an area where avian influenza is a concern.

WHO encourages countries to continue strengthening influenza surveillance, including surveillance for severe acute respiratory infections (SARI) and to carefully review any unusual patterns, in order to ensure reporting of human infections under the IHR (2005), and continue national health preparedness actions.



## **NATIONAL DISEASE REPORTS\***

**RICIN (OKLAHOMA):** 27 April 2014, An Oklahoma man is accused of attempting to hire someone to pretend to be a delivery man to give his pregnant girlfriend a pizza with ricin on it. The 30-year-old man remains jailed without bond in Oklahoma City on 2 counts of attempting to kill another and 3 counts of solicitation to commit murder. According to The Oklahoman (a news organization), the accused was arrested on 17 Apr 2014 after authorities learned of a conversation he had with a former co-worker. The affidavit says the accused produced a vile of ricin, a deadly toxin, during a meeting with the man, and told him to use the toxin to poison his girlfriend. The arrest report goes on to say that his girlfriend is pregnant with his child, and the accused man wanted to kill the fetus. He is accused of then asking the man to put the ricin in a soft drink or pizza and pretend to be a delivery man in order to get his girlfriend to ingest the toxin. The police added that he said that if his girlfriend were to die in the process, he would be okay with it. (Ricin Toxin is listed in Category B on the CDC List of Critical Biological Agents) \*Non-suspect case

**FOODBORNE ILLNESS (USA):** 28 April 2014, More than 100 people have now reported that they became ill with possible foodborne illnesses at a national Food Safety Summit held earlier in April 2014 in Baltimore, MD. Maryland state health officials say they still don't know what caused the outbreak of gastroenteritis that left participants suffering symptoms that included diarrhea and nausea. "We are working on evaluating possible exposures and doing testing at the Maryland state public health laboratory to attempt to identify an agent," officials said in a letter to attendees. The conference, held from 8-10 Apr 2014 at the Baltimore Convention Center, attracted at least 1300 of the top food safety officials in the nation, including staff from federal agencies such as the FDA and the CDC as well as businesses such as McDonald's, Tyson, and ConAgra Foods. Health officials have heard back from about 400 of those who attended, so the actual toll of illness might be higher. City health officials inspected the convention center and its food service provider, Centerplate. The company was issued a violation notice for condensation dripping from one of the 2 ice machines in the kitchen, a spokesman said. (Food Safety Threats are listed in Category C on the CDC List of Critical Biological Agents) \*Non-suspect case

**MERS-COV (USA):** 02 May 2014, Middle East respiratory syndrome coronavirus (MERS-CoV) was confirmed today [2 May 2014] in a traveler to the United States. This virus is relatively new to humans and was 1st reported in Saudi Arabia in 2012. "We've anticipated MERS reaching the US, and we've prepared for and are taking swift action," said CDC Director Tom Frieden, M.D., M.P.H. "We're doing everything possible with hospital, local, and state health officials to find people who may have had contact with this person so they can be evaluated as appropriate. This case reminds us that we are all connected by the air we breathe, the food we eat, and the water we drink. We can break the chain of transmission in this case through focused efforts here and abroad."

On [24 Apr 2014], the patient traveled by plane from Riyadh, Saudi Arabia to London, England then from London to Chicago, Illinois. The patient then took a bus from Chicago to Indiana. On [27 Apr 2014], the patient began to experience respiratory symptoms, including shortness of breath, coughing, and fever. The patient went to an emergency department in an Indiana hospital on [28 Apr 2014] and was admitted on that same day. The patient is being well cared for and is isolated; the patient is currently in stable condition. Because of the patient's symptoms and travel history, Indiana public health officials tested for MERS-CoV. The Indiana state public health laboratory and CDC confirmed MERS-CoV infection in the patient this afternoon [2 May 2014]. "It is understandable that some may be concerned about this situation, but this 1st U.S. case of MERS-CoV infection represents a very low risk to the general public," said Dr. Anne Schuchat, assistant surgeon general and director of CDC's National Center for Immunizations and Respiratory Diseases. In some countries, the virus has spread from person to person through close contact, such as caring for or living with an infected person. However, there is currently no evidence of sustained spread of MERS-CoV in community settings.

CDC and Indiana health officials are not yet sure how the patient became infected with the virus. Exposure may have occurred in Saudi Arabia, where outbreaks of MERS-CoV infection are occurring. Officials also do not know exactly how many people have had close contact with the patient. So far, including this U.S. importation, there have been 401 confirmed cases of MERS-CoV infection in 12 countries. To date [2 May 2014], all reported cases have originated in 6 countries in the Arabian Peninsula. Most of these people developed severe acute respiratory illness, with fever, cough, and shortness of breath; 93 people died. Officials do not know where the virus came from or exactly how it spreads. There is no available vaccine or specific treatment recommended for the virus. "In this interconnected world we live in, we expected MERS-CoV to make its way to the United States," said Dr. Tom Frieden, Director, Centers for Disease Control and Prevention. "We have been preparing since 2012 for this possibility." Federal, state, and local health officials are taking action to minimize the risk of spread of the virus. The Indiana hospital is using full precautions to avoid exposure within the hospital and among healthcare professionals and other people interacting with the patient, as recommended by CDC.

In July 2013, CDC posted checklists and resource lists for healthcare facilities and providers to assist with preparing to implement infection control precautions for MERS-CoV. As part of the prevention and control measures, officials are reaching out to close contacts to provide guidance about monitoring their health. While experts do not yet know exactly how this virus is spread, CDC advises Americans to help protect themselves from respiratory illnesses by washing hands often, avoiding close contact with people who are sick, avoid touching their eyes, nose and/or mouth with unwashed hands, and disinfecting frequently touched surfaces. The largest reported outbreak to date occurred April through May 2013 in eastern Saudi Arabia and involved 23 confirmed cases in 4 healthcare facilities. At this time, CDC does not recommend anyone change their travel plans. The World Health Organization also has not issued Travel Health Warnings for any country related to MERS-CoV. Anyone who develops fever and cough or shortness of breath within 14 days after traveling from countries in or near the Arabian Peninsula should see their doctor and let him or her know where they travelled. (Emerging Infectious Diseases are listed in Category C on the CDC List of Critical Biological Agents) \*Non-suspect case

## **INTERNATIONAL DISEASE REPORTS\***

**LEPTOSPIROSIS (ARGENTINA):** 28 April, 2014, An outbreak of leptospirosis, an infectious disease that is generally transmitted from rats to humans and capable of causing a clinical condition ranging from fever to multiple organ damage, has been detected in San Justo, the main city of the department bearing the same name in Santa Fe Province, Argentina. Of the 6 cases that were officially confirmed by the Santa Fe Health Ministry, one person has died, and there are 3 people severely affected. These latter people presented with a "non-specific febrile illness, upon which a clinical diagnosis of leptospirosis was assumed, considering epidemiological background, clinical features, laboratory tests performed, and because of living in the vicinity of flooded areas as a consequence of the recent heavy rainfall," explained an officer of the Provincial Health Promotion and Prevention Office. The affected people are currently living in the vicinity of flooded areas, near Rio Salado, which went out of its course nearly 10 days ago, after a 350 mm rainfall. There is a team belonging to the Health Promotion and Prevention area working alongside local teams in order to reinforce reporting suspicious cases and also looking for cases of non-specific febrile illness, taking appropriate samples, and prescribing early therapy. The team is also reviewing the local



environmental conditions so appropriate measures may be taken in order to improve the quality of life of the population.

Leptospirosis is a bacterial disease affecting animals and humans. It is also known as swamp fever, since one way of acquiring this condition is related to exposure to water, mud, flooded land, and overflowing rivers. Rats are the main reservoir for the disease, because they shed *Leptospira* bacteria, the causative agents for this disease, in their urine, contaminating the environment. Domestic animals that are more prone to developing this disease are dogs, cattle, pigs, and horses. Vulnerable people are those who might have been exposed to floods during the last few weeks or those performing sports or working activities in streams, lagoons, wells, and particularly in stagnant water. It is also possible to acquire the disease by contact of skin or mucosa contact with mud as well as with wet materials (cleared land, garbage) contaminated with urine of [infected] rats. Humans who become infected following exposure to water or through the consumption of contaminated foods may develop an illness that ranges from an influenza-like condition to a severe disease that may present with liver, kidney, and lung involvement. Usual symptoms include fever, headache or muscle pain, reddening of the conjunctivae, rash, nausea, and vomiting, which may occur after an incubation period lasting from 1-2 weeks, and if such manifestations should occur, the affected person must go as soon as possible to the nearest health center. Physicians, after performing a clinical examination, may request some laboratory tests in order to confirm or rule out the diagnosis. If the disease is confirmed, then antibiotic therapy is indicated. [Antibiotic therapy is often started on suspicion of the diagnosis of leptospirosis prior to laboratory confirmation because of the potentially fatal course of severe untreated leptospirosis.] With respect to preventive measures, health authorities emphasized the importance of avoiding contact with stagnant waters, the use of adequate protective measures (boots and gloves) when working in risky areas and to properly eliminate underbrush from houses, as well as maintaining properly clean yards and wastelands. They also recommended that openings that might be used by rats to enter households must be sealed, and garbage and waste must be properly eliminated so there may be no shelters for rodents. Garbage must also be placed in adequately covered receptacles. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) \*Non-suspect case

**CHOLERA, DIARRHEA AND DYSENTERY (AFRICA):** 30 April 2014, At least 3 children have been reported to have died of cholera in an outbreak in Ba'adweyne village in the central Somali region of Mudug. Mohamed Said Ahmed, an official from Ba'adweyne told Bar-kulan that the cholera cases have been reported in the area 3 days ago. He added that there has not been any emergency response to counter the outbreak and appealed for immediate assistance. Meanwhile, Dr Mohamed Ahmed Shino who is one of the medical practitioners in Galkayo Hospital stated that at least 13 people affected by the cholera outbreak including elderly and children have been admitted to the hospital. Dr Shino believes that the cholera outbreak was caused by contaminated water coupled with a searing heat in the region. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) \*Non-suspect case

**EBOLA VIRUS DISEASE (GUINEA):** 02 April 2014, 2 new cases of Ebola virus disease (EVD) in Guinea and 6 more deaths as of last evening [1 May 2014] were reported today by the World Health Organization (WHO). That brings the cumulative total to 226, with 149 deaths. Of 210 cases tested, 127 have been laboratory-confirmed; this includes 81 fatal cases. Another 44 cases with 34 deaths have been classified as probable, and 55 with 34 deaths have been classified as probable [sic - this is quite confusing. - Mod.JW]. Cases in healthcare workers stand at 25 with 18 confirmed, and deaths among this group are 16, with 11 of those in confirmed cases. The geographic areas of Guinea with the most cases are Guekedou with 140 cases and 99 deaths, and Conakry, the capital, with 53 cases and 24 deaths. Tracing of contacts is continuing in these 2 areas. The WHO states that because EVD's incubation period can be as long as 3 weeks, more cases are likely to be reported in coming weeks. It further notes that the recent availability of Ebola virus serology testing for use in patients with clinical disease but negative findings on polymerase chain reaction [PCR] tests may change the number of confirmed cases. (Viral Hemorrhagic Fever is listed in Category A on the CDC List of Critical Biological Agents) \*Non-suspect case

**FOODBORNE ILLNESS (CANADA):** 02 May 2014, Several high school students in North Vancouver [British Columbia] have become ill after eating pot-infused edibles resulting in one Grade 10 student being sent to hospital, according to police. North Vancouver RCMP (Royal Canadian Mounted Police) spokesperson Cpl. Richard De Jong said police will be working with the North Vancouver School District to educate students and parents to ensure school properties are drug free. "Making these edibles widely available and normalized can be very tempting to children," De Jong said. "The allure of these marijuana edibles, which taste and look like simple sweets, makes them especially risky." Photos released to media show 2 different marijuana-infused snacks including a Rice Krispy Square and brownies that were confiscated by police. Children who ingest marijuana can become ill, RCMP said, with how sick they get depending on the child's age, weight, the potency of the drug, and how much is eaten. "To a young person the risk of ingesting edible marijuana is that the danger is camouflaged by the product looking safe and familiar," De Jong said. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) \*Non-suspect case

National and International Disease Reports are retrieved from <http://www.promedmail.org/>.

## **OTHER RESOURCES AND ARTICLES OF INTEREST**

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: <http://preparedness.dhmv.maryland.gov/> or follow us on Facebook at [www.facebook.com/MarylandOPR](http://www.facebook.com/MarylandOPR).

Maryland's Resident Influenza Tracking System: <http://dhmv.maryland.gov/flusurvey>

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**NOTE:** This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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## Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

**Table: Text-based Syndrome Case Definitions and Associated Category A Conditions**

<b>Syndrome</b>	<b>Definition</b>	<b>Category A Condition</b>
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF  ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

**Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents**  
(continued from previous page)

<b>Syndrome</b>	<b>Definition</b>	<b>Category A Condition</b>
Respiratory	<p>ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media)</p> <p>SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus</p> <p>ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis</p> <p>ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain</p> <p>EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE <i>acute exacerbation</i> of chronic illnesses.)</p>	<p>Anthrax (inhalational)</p> <p>Tularemia</p> <p>Plague (pneumonic)</p>
Neurological	<p>ACUTE neurological infection of the central nervous system (CNS)</p> <p>SPECIFIC diagnosis of acute CNS infection such as pneumococcal meningitis, viral encephalitis</p> <p>ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephalitis NOS, encephalopathy NOS</p> <p>ACUTE non-specific symptoms of CNS infection such as meningismus, delirium</p> <p>EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's</p>	Not applicable
Rash	<p>ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs)</p> <p>SPECIFIC diagnosis of acute rash such as chicken pox in person &gt; XX years of age (base age cut-off on data interpretation) or smallpox</p> <p>ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem</p> <p>EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheic dermatitis, rosacea</p> <p>EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema</p>	Smallpox
Specific Infection	<p>ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal)</p> <p>INCLUDES septicemia from known bacteria</p> <p>INCLUDES other febrile illnesses such as scarlet fever</p>	Not applicable

**Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents** (continued from previous page)

<b>Syndrome</b>	<b>Definition</b>	<b>Category A Condition</b>
Fever	<p>ACUTE potentially febrile illness of origin not specified</p> <p>INCLUDES fever and septicemia not otherwise specified</p> <p>INCLUDES unspecified viral illness even though unknown if fever is present</p> <p>EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome</p>	Not applicable
Severe Illness or Death potentially due to infectious disease	<p>ACUTE onset of shock or coma from potentially infectious causes</p> <p>EXCLUDES shock from trauma</p> <p>INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births</p> <p>EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths</p>	Not applicable